Toronto Central **LHIN**

Partners in Action: Delivering Excellent Care for All

Annual Report 2011/2012

Transforming the system for *your health*

Ontario
Local Health Integration Network

Contact Information

Telephone:
416.921.7453
1.866.383.5446

Address:
425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4

E-mail:
torontocentral@lhins.on.ca

Website:
www.torontocentrallhin.on.ca
www.lhins.on.ca
www.health.gov.on.ca/transformation/lhin/lhin_nun.html

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Executive Summary

About the LHIN

The Toronto Central Local Health Integration Network (LHIN) is the only completely urban health region in Ontario. There are approximately 1.15 million people living in the TC LHIN catchment area and local health care organizations provide services to hundreds of thousands of Ontarians from other regions.

The LHINs are responsible for managing the health system at the local level. What's unique about the LHINs' role is that we have a view of the entire health care system. We look across the system to see where the gaps are for clients. And we plan services so that resources go where there is the greatest need.

Hospitals, community support services agencies, the Community Care Access Centre, mental health and addictions services, long-term care homes and community health centres are funded through the LHINs. Currently 170 health service providers receive operating funding through the TC LHIN.

Progress in Challenging Times

2011/12 was a period of significant change including the global and provincial economic downturn, a provincial election, city budget uncertainty, and the beginning of significant health care reform in the province.

On the whole, the health care system in the Toronto Central LHIN has responded well to change and made progress in key areas.

The TC LHIN assumed a larger role in steering health system change. The TC LHIN updated its Strategic Plan at the beginning of 2011/12, by building on the Integrated Health Services Plan-2 with two new elements: Optimizing Internal Capacity and a Quality Improvement Strategy.

The overarching goal for 2011/12 was to deliver on Excellent Care for All at the local level. Our focus is on improving all aspects of quality care with a particular emphasis on tackling health inequities.

→ Access to care

Access to services improved in some key areas and worsened in others over the past year:

- People are being treated and out of the ER faster than they were a year ago. Just short of 90% of patients with minor conditions and those who are seriously ill but do not require admittance are being treated within targets - four hours and 8 hours respectively. However, there is still more work to do to improve wait-times for patients requiring admission to hospital. As of the third quarter of 2011/12, only 36% of patients were admitted from the ER to hospital within the recommended timeframe. Innovations including short-stay units that treat patients for short periods are helping to free up inpatient beds for those who need them.
- This year people were spending less time unnecessarily in hospitals waiting to be transferred to another place for ongoing care. This is known as the Alternate Level of Care (ALC) rate - a measure that tells us the number of people who are ready to be discharged from the hospital but can't leave because the services they need at home or in another setting are not in place. ALC dipped to under the LHIN's 10% target for the first time last year, a notable achievement given the LHIN's aggressive ALC target. This means that more people are receiving care at home, in the community, or other settings once their hospital care is over.
- These accomplishments are even more significant considering that the demand for ER and other hospital services in the Toronto Central LHIN increased substantially in 2011/12.
- Mental health and addictions (MHA) clients receiving services in the TC LHIN now have single access points for key services – supportive housing, case management and Assertive Community Treatment Teams (ACTT).
- More people are being seen within the target wait times for MRIs.

- ER patients used to wait longer than inpatients for CT scans. This year, hospitals are providing access to all hospital patients based on need. ER patients are now getting faster access whereas those with less urgent needs are waiting longer. This is one of the main factors behind the increase in CT wait times this year.
- Waits for hip and knee replacement surgery have gone up mainly because more patients are coming to the TC LHIN from elsewhere and some patients are choosing to wait for preferred surgeons. However, when people waiting for preferred surgeons are not included in the count, most patients are waiting within with the recommended timeframe.
- Resource Matching and Referral (RM&R) is improving patient referrals across the system. One of the fastest moving regional health information implementations in Ontario, TC LHIN's RM&R system involves 84 health service providers across the care spectrum and over 24,000 health professionals using one solution to allow patients to make the transfer process smoother and faster for patients.

→ Quality

As part of the Toronto Central LHIN's Quality Improvement Strategy, a number of initiatives were launched to improve quality of care for high-needs populations including frail elderly and people with mental health and addictions issues.

Building on the TC LHIN's local success, all 155 hospitals in the province are participating in the Senior Friendly Hospital Strategy. By the end of the year, all hospitals completed self-assessments that will form the basis for a plan to create safer and more supportive hospital environments for seniors.

Behavioural Supports Ontario (BSO) Strategy was initiated locally to enhance services for seniors with behavioural issues resulting from dementia and mental illness.

Patient Experience

The patients' experience is a key element of quality care. A number of initiatives in the TC LHIN last year were designed to put patients and caregivers in charge of their care. Through the Caregiver Framework for Seniors Pilot Project, patients and caregivers work with the case coordinator to develop a care plan that meets the unique needs of the caregiver and patient. This initiative is building caregiver resiliency and reducing their risk of burnout. A support model for caregivers of children was also launched in the TC LHIN last year.

The TC LHIN begins health system planning by asking what patients need. We look at the evidence and we listen to what patients and caregivers say is important to them. The TC LHIN and Patient Destiny – a consumer-led group that advances patient involvement in their care – co-hosted a session with a broad group of patients in the LHIN. This report Meeting with Patients: Their Experiences and Perspectives is informing the TC LHIN and health care organizations as we plan services.

Measurement

A cornerstone of the LHIN's quality improvement strategy is the development of one set of quality indicators for the system. The LHIN brought together an expert group of health professionals, all LHIN-funded sectors, primary care, Toronto Public Health, ICES, Health Quality Ontario and patient and caregiver representatives to recommend indicators for all providers to adopt. In the past, quality indicators were developed in pockets with each sector tackling different problems and often pursuing separate goals. This is the first time that all providers in a region are working toward one set of goals. This approach will have a much greater impact on patient care and the health system.

→ Equity

Health equity is an integral part of quality health care. Following are a few examples of how health equity is being addressed in the TC LHIN.

Aboriginal Community – Culture-based Care

Anishnawbe Health Toronto, in partnership with the TC LHIN, launched the Urban Aboriginal Diabetes Research Report, a groundbreaking report that underscores the need for culture-based approaches to delivering health care to urban Aboriginal communities.

An Aboriginal Youth Mental Health and Addictions Initiative was launched last year. Projects will be selected based on areas of need and success factors identified by the Aboriginal community members. Anishnawbe Health Toronto is the project lead for the first phase which involved broad Aboriginal community and youth engagement. Projects will be selected mid-summer 2012.

In 2012/13, programs there will be new programs in place to improve the health status of Aboriginal youth experiencing mental illness and/or addictions.

Health Access St. James Town was initiated in the TC LHIN in 2011 to integrate a range of health and social services in this densely populated neighbourhood so that they better meet residents' needs.

The TC LHIN's Health Action Equity Plan, launched last year, has three strategies to address disparities:

- Share and expand phone interpretation for non-English speaking people;
- Better access for populations without health insurance;
- Equity indicators and equity data collection at point of care.

→ System Capacity and Planning

During the past year, the TC LHIN began developing a strategy to strengthen and integrate primary care with the local system. The TC LHIN brought on three Toronto-based family physicians as key advisors who will lead primary care engagement.

Looking Ahead

While we have made progress in the health care system over the past year, significant challenges remain.

Services are fragmented and people find it confusing and difficult to get from one part of the system to another.

And while Toronto is rich in diversity it is also marred by health inequities.

As a result of the prolonged economic downturn and the province's historic $15 B deficit, in the next few years we cannot count on new funding to resolve our health care challenges.

In the year ahead, the TC LHIN and health services providers will step up efforts to transform the health care system to improve health outcomes and sustain the system for the future.

Letter from the Board Chair and CEO

We are pleased to present the Toronto Central (TC) LHIN's Annual Report on the local health care system for 2011/12.

Angela Ferrante
Board Chair

While we are getting new and better information on health system performance, what matters most is what patients are telling us.

Over the past year there have been a number of revealing reports that have shed light on how patients view their experiences with the health care system. They include a report by Patient Destiny – a Toronto-based patient advocacy group – which held a session with local patients and caregivers for the TC LHIN. The report makes it clear that patients seem to have very good experiences with individual health professionals and organizations. However, problems occur when people transition between different parts of the system. People find the web of services fragmented and confusing. The fact that many agencies and clinics are not open on weekends is a real problem for those who can't wait for care. Some say they don't get good information either about services or their own situation and feel excluded from decisions affecting their lives.

Camille Orridge
CEO

At the TC LHIN we have made notable improvements this past year addressing some of these issues. We equally believe that we must step-up our efforts where we are lagging behind.

Overall this past year clients of our health system have benefitted from improved access to key services. Patients waited less time in local Emergency Rooms for treatment. At the same time people were spending less time unnecessarily in hospitals because of a lack of capacity in the places where they needed to be. We call this the Alternate Level of Care (ALC) rate and we are pleased that it has gone down. This means that more people are receiving care at home, in the community, or other settings once their hospital care is over.

On the other hand, patients are waiting longer than our target wait times for certain procedures, for example hip and knee replacement surgery.

This past year the Toronto Central LHIN's overriding goal was to make sure all people receive excellent care. This flows directly from the government's Excellent Care for All Act that calls on the system to put patients first by improving their experience in the health care system.

Our part in helping to achieve this goal involves consulting with quality experts, patients and caregivers to recommend a set of quality metrics that all health service providers will be adopting next year. Those metrics will apply to all hospitals, community agencies and long-term care homes in the TC LHIN.

Last year saw the launch of new quality improvement initiatives including the local Behavioural Support Ontario Strategy to assist people with severe behavioural issues resulting from dementia or mental health and addictions. As well, the TC LHIN launched the Caregiver Framework for Seniors and Children which is helping to alleviate caregiver burnout.

We are also concerned that Torontonians receive different standards of care depending on where they live and who they are.

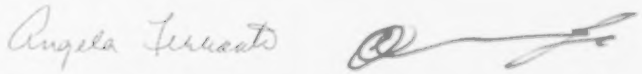
As part of overall quality improvement, the LHIN also launched a Health Equity Action Plan. Initiatives such as the TC LHIN's shared over-the-phone interpretation service for non-English-speaking patients break down some of the barriers that disadvantaged populations face when they try to access services.

In 2011/12, the TC LHIN and health care organizations looked beyond immediate health care issues by planning ahead and finding new ways to improve services for patients. Many of the problems we face today have been with us for some time. However, the current challenges and the solutions available to us are also fundamentally different. The answers do not lie within single organizations. They are found in collective efforts, at the system level.

For example, hospitals are leading the charge on system-wide efforts to reconfigure clinical services to achieve better health outcomes and value for money – starting with a GTA project to improve how stroke patients move from the operating table to rehabilitation. Community agencies are working together to make it easier for seniors and other clients to access a range of services in their neighbourhoods.

These achievements show the art of the possible in health care.

The Board of Directors and the staff of the Toronto Central LHIN look ahead with optimism and excitement. We look forward to working with our partners to build a strong, sustainable local health system for everyone.



Angela Ferrante
Board Chair

Camille Orridge
CEO

Community Snapshot: Toronto Central LHIN at a Glance

Approximately 1.15 million people reside in the Toronto Central LHIN. This is 8.6% of the population of Ontario. It's the most densely populated and only completely urban LHIN. According to the latest projections, more than 1.16 million people will be living in Toronto Central LHIN by 2016, accounting for 8.2% of the province's total residents.

Toronto Central is a picture of diversity. Immigrants make up 41 per cent of the population and there are more than 160 languages and dialects spoken here.

The City of Toronto has a French-speaking population of about 53,370. According to the 2006 Census, 7.4 per cent of Francophones in the City are recent immigrants and 20.6 per cent are part of a visible minority group.

In the City of Toronto, there are approximately 25,000 Aboriginal peoples (2006 Census) who comprise 0.5 per cent of the population. This is thought to under-represent the actual numbers as the Census data does not capture the large number of Aboriginal people who are homeless or those who migrate between the city and their home communities during the year. There are an estimated 16,200 residents of Aboriginal ancestry (1.5 per cent) in the Toronto Central LHIN.

The Toronto Central LHIN has the largest lesbian, gay, bisexual and transgendered community in Canada.

There are also vast differences in incomes and educational levels in Toronto, ranging from some of the most affluent neighbourhoods in Canada to some of the poorest. Twenty-four per cent of the population is low income and there are over 5,000 homeless people in the LHIN.

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An Aging Population

Compared to the rest of the province, a higher proportion of young adults live in the Toronto Central LHIN. Thirty-two per cent of people in the LHIN are between the ages of 22 to 44.

Like the rest of Ontario, TC LHIN's population is greying. Seniors aged 65 years and older accounted for 14 per cent of the population in 2011. This demographic is projected to grow faster than any other age group. People aged 75 to 84 accounted for five per cent of the population. Between 2016 to 2031, this group is projected to make up 45 per cent of the population. Today, seniors are living longer and healthier, which brings tremendous social and economic benefits. At the same time, health care use and costs rise as people age. With the aging baby boomer bulge health care costs will inevitably continue to grow.

Who Comes to Toronto Central LHIN for Care

A number of hospitals in this LHIN provide specialized services not offered anywhere else in Ontario. As a result, many people from out of town come to Toronto Central for medical services. Some 55.5 per cent of patients in Toronto Central LHIN hospitals and 41 per cent of alternate level of care patients discharged from Toronto Central LHIN acute care hospitals live in other LHINs.

Addressing the Health Needs of the Population

More than one in three TC LHIN residents has at least one chronic condition and many have multiple physical and mental health conditions. Nearly one in 10 adults in the TC LHIN lives with diabetes. Mental health illness and addictions affect one in five Ontarians in their lifetime.

Toronto Central LHIN Health Service Providers Key Facts

- There are 170 health service providers in the Toronto Central LHIN, including 17 hospitals, 17 community health centres, 37 long-term care homes, one Community Care Access Centre, 67 community support agencies and 69 mental health and addictions organizations are funded through the Toronto Central LHIN. (Some health service provider organizations deliver more than one service, e.g., hospital and long-term care services.)
- Toronto Central LHIN is home to 38 per cent of Ontario's teaching hospitals.
- Community agencies vary greatly in their size and the types of services they deliver. For example, in the community support sector agency total budgets range from under $100,000 to over $30M.

Engaging the Toronto Central LHIN Community

Community engagement helps ensure that decisions made in the local health care system are informed by the experiences and perspectives of those who use the services as well as those involved in service delivery.

In 2011/12 the Toronto Central LHIN released an annual community engagement plan. The plan described how we will consult and work with communities and stakeholders.

Public and Patients

The Toronto Central LHIN's Community Engagement Task Group with representatives of all health service provider sectors conducted a "who is doing what" survey regarding community engagement. It revealed that there is a high level of patient and community engagement

in the Toronto Central LHIN. There are also significant opportunities for providers to collaborate to improve the impact and experience of the communities being engaged. The survey also highlighted some gaps in engaging certain communities.

In 2011, Toronto Central LHIN released its inaugural Report to the Community: Partners in Action which highlights local health system progress and challenges and what they mean for the people we serve.

Meeting with Patients

Toronto Central LHIN, in partnership with Patient Destiny, co-hosted a Meeting with Patients in early December 2011. The session brought together a cross-section of patients and caregivers to discuss their experiences, perspectives and ideas for improvement. The resulting report, "*Meeting with Patients: Their Experiences and Perspectives*" is being used by the LHIN for system planning including the Toronto Central LHIN's 2012-14 Strategic Plan. The report has been broadly distributed within the TC LHIN and across the province. TC LHIN providers have been encouraged to use the report and a number have confirmed that they are incorporating it into their planning and decision-making processes.

> "I want the system to work more efficiently. It will make us healthier and I think it will cost the system less."
>
> **Erella,** *participant, Meeting with Patients: Their experiences and perspectives*

The TC LHIN partnered and participated in various other events focused on the client experience and health equity. For example, CEO Camille Orridge made a keynote presentation at the Healthy Connections Conference put on by Ryerson University, TC LHIN, and Canadian Research Network for Care in the Community on the topic of Mobilizing a System Response to Caregiver Support.

TC LHIN's Board in the Community

The Board of the Toronto Central LHIN is committed to hearing the voices of patients and community stakeholders.

Members of the public and patients now have another way of bringing their ideas and concerns to the Board. Groups can request to make presentations at Board meetings. This is in addition to regularly scheduled discussions with stakeholders at Board meetings.

The Board participates in a community tour at least once a year. Last year, TC LHIN Board members visited Access Alliance CHC as well as Crescent Town and Teesdale – two high density neighbhourhoods in Toronto's east end. Board members met with tenants and heard about their concerns, needs and aspirations for their communities. Board members also visited the enhanced Adult Day Program at WoodGreen Community Services to see first-hand how this innovative model is helping seniors with high-needs to live full and active lives in their communities.

Caregivers Initiative

Community engagement is a core component of all TC LHIN projects. For the Caregiver for Seniors Framework led by the Alzheimer Society of Toronto, seniors and others, including the French Language Health Services Entity (Reflet Salvéo), were involved in the Advisory Committee for the project. Caregivers from diverse backgrounds were involved in the design and evaluation of the pilots.

Last year, a group of service providers and a concerned residents group celebrated the opening of the St. James Town Community Corner – a place where both tenants and service providers can collaborate to meet the needs of residents, especially those living with chronic health issues or facing social isolation and barriers.

The "Corner" is supporting the Health Access St. James Town project in the TC LHIN. The Corner has already demonstrated what collaboration between residents, who understand the neighbourhood better than anyone, and service providers can do in St. James Town.

"To encourage the uptake of services, one needs to bring services to the community and make the services relevant to them – not just primary health, but other health services too. Bringing services to the community – services that people actually want and need – helps to build a sense of belonging and ownership."

Ravi Subramaniam, *long-time resident and community worker in St. James Town*

Francophone Community

The Toronto Central LHIN continued to strengthen its Francophone engagement efforts during 2011/12. At the beginning of the year the TC LHIN hosted a focus group to get input on the health system's strategic priorities for the health care system. This event brought together business and community leaders as well as representatives of the diverse Francophone community including immigrants, people living with HIV/AIDS and women.

2011/12 marked the French Language Health Service Planning Entity's (Reflet Salvéo) first year of operations. During this start-up year, the Entity began the process of identifying and engaging the diverse Francophone communities in the Toronto Central, Central West and Mississauga Halton LHINs to understand community needs and challenges.

Toronto Central is focused on gaining a better understanding of the needs of underserved Francophone groups such as newcomers and refugees. Reflet Salvéo conducted an environmental scan of community needs, issues and gaps based on evidence and community input.

Toronto Central LHIN is on track with its own French Language Services (FLS) improvement plan. This included various efforts to build awareness of the LHINs' and providers' legislative obligations for FLS.

The TC LHIN convened a FLS Core Group with representatives from all health service provider sectors to work together on strategies to enhance access to FLS across the system, while maximizing existing system resources.

Aboriginal Community

According to the latest Census, 62 per cent of Aboriginal people in Ontario live in urban areas.

Toronto has one of the largest and most diverse Aboriginal populations in Canada.

Last year, the TC LHIN was involved in a number of partnerships to develop culturally relevant, community-based strategies to address the health needs of Aboriginal communities in and around Toronto.

In addition, the LHINs are collaborating on issues affecting all First Nations, Metis, Inuit and Aboriginal communities across the province. The Toronto Central LHIN chaired the Provincial LHIN Aboriginal Leads group. The 14 LHINs held a Joint Planning Session to develop joint strategies for pressing Aboriginal health issues including mental health and addictions and diabetes.

Following are the highlights of the TC LHIN's inclusive approach to working with Aboriginal people.

Aboriginal Advisory Circle

Toronto Central LHIN worked with Aboriginal agencies and community leaders over the past year to create an Aboriginal Advisory Circle – a community-led group that provides guidance regarding Aboriginal health issues and initiatives in Toronto. This Circle is comprised of Aboriginal and non-Aboriginal representatives from hospitals, community agencies, the City of Toronto, academia and an Urban Elder.

Aboriginal Youth and Mental Health and Addictions Initiative

An Aboriginal Youth Mental Health and Addictions Initiative was launched last year. Projects will be selected based on areas of need and success factors identified by the Aboriginal community members. Anishawbe Health Toronto is the project lead for the first phase which involved broad Aboriginal community and youth engagement. Projects will be selected mid-summer 2012.

In 2012/13, programs will be put in place to improve the health status of Aboriginal youth experiencing mental illness and addictions.

Urban Aboriginal Diabetes Research Report

In partnership with Anishnawbe Health Toronto, the Toronto Central LHIN launched the Urban Aboriginal Diabetes Research Report. This groundbreaking report revealed the need for a new model of culture-based care for the Aboriginal community, one of Toronto's most vulnerable and hidden populations. The TC LHIN held public events to launch the report and it has garnered significant local and international attention.

Aboriginal Health Equity Partnership

The five GTA LHINs have partnered with the Noojimawin Health Authority to identify joint opportunities for improving the health of at-risk urban Aboriginal communities. The group will soon release the findings of a report on Aboriginal health equity and highlight lived experiences of Aboriginal peoples accessing in services in GTA hospitals and other organizations.

Health Professionals and Workers

The Toronto Central LHIN's Health Professionals Advisory Committee (HPAC) is comprised of 14 leaders representing a range of health professions. This year Dr. Pauline Pariser, physician-lead for the Taddle Creek Family Health Team, completed her term as Chair and Dr. Samir Sinha, Director of Geriatrics at Mount Sinai Hospital assumed the Chair role. HPAC brings a variety of clinical and health professional perspectives to the TC LHIN. HPAC members founded the TC LHIN Quality Indicator Working Group and bring an invaluable voice to TC LHIN initiatives including Senior Friendly Hospital, Discharge Planning, Primary Care for Homebound Seniors and ConnectingGTA.

Health professionals from a variety of disciplines play pivotal roles in various TC LHIN system initiatives including the ER Wait Time Strategy, Virtual Ward, implementing Stroke and Orthopedic best practices, and mental health and addictions coordinated access projects.

The Toronto Central LHIN partnered with the Ontario Medical Association District 11 to lead a focus group with family physicians and specialists regarding strategies to improve care transitions and the management of people with mental illness and addictions.

Health Service Providers

The Health Service provider Leadership Forum is a platform for executives from all sectors to address health system issues. The Health Service Provider Leadership forum has two meetings a year and advances opportunities to collaborate and share resources across sectors. One example is the TC LHIN-Toronto Community Health Profiles – Wellbeing Toronto Health Data Partnership, a tool that provides a comprehensive profile of health outcomes and wellbeing within neighbourhoods and at a system level.

The Sector Tables provide a venue for CEOs and Executive Directors to meet together within each sector to raise system issues and pursue strategies to improve care and maximize resources.

2011/12: A Year of Progress

On the whole, the health care system in the Toronto Central LHIN has responded well to change and made progress in key areas.

The TC LHIN assumed a larger role in steering health system change this past year. The TC LHIN also took on overall operational and governance responsibility for LHIN Shared Services Office (LSSO) and LHIN Collaborative (LHINC) supporting the 14 LHINs. A foundational year for LSSO and LHINC, both ended the year on solid footing and improved the efficiency and the collective impact of the 14 LHINs as health system managers.

The TC LHIN updated its Strategic Plan at the beginning of 2011/12, by building on the Integrated Health Services Plan-2 with two new elements: Optimizing Internal Capacity and Quality improvement Strategy.

Our overarching goal for 2011/12 is delivering on Excellent Care for All at the local level. We focus on improving all aspects of quality care with a particular emphasis on equity given the disparities in quality of care and health outcomes in Toronto.

Access to Care

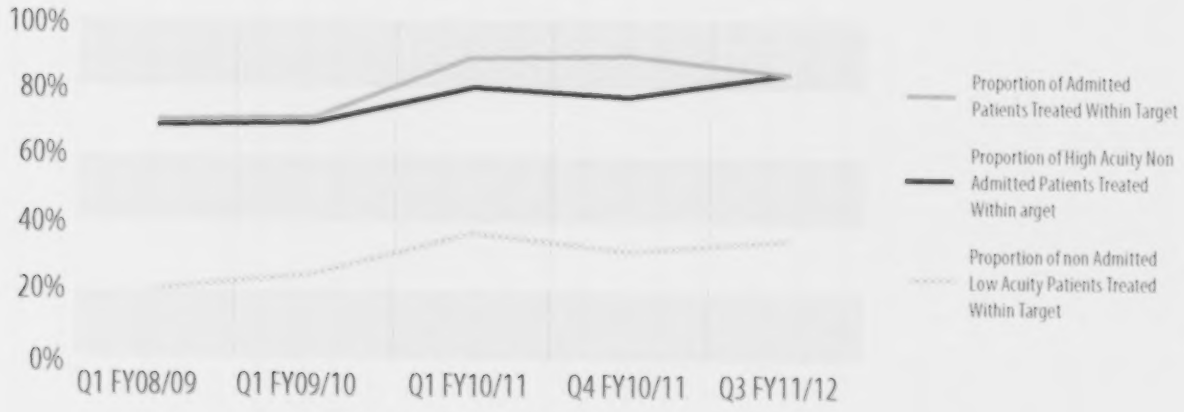
Access improved for some key services and worsened for other over the past year.

People are being treated and out of the ER faster than they were a year ago. Just under 90% of patients with minor conditions and patients who are seriously ill but do not need to be admitted are being treated within targets. ER wait times have improved even though the demand for ER has increased by 6.6 per cent in the TC LHIN.

The challenge remains timely treatment of those who need to be admitted to hospital. The primary reason is challenges with the flow of discharged patients from the hospital. As of Q3 only 36% of patients were admitted from the ER to hospital within the recommended timeframe. Innovations including short-stay units that treat patients for short periods instead of being admitted are helping to free up inpatient beds for patients who need them.

This year the TC LHIN continued to make steady progress on reducing ALC rate. ALC *dipped to under 10%* for the first time last year.

Proportion of ER Patients Treated within Target



This means fewer people are in hospital when they should be and would often prefer to be elsewhere. This is largely attributed to success in the flagship Home First program as well as other Aging at Home initiatives that are allowing seniors to receive ongoing care in their homes and communities.

The goal now is to maintain these gains while focusing on improving the flow of patients in and out of rehab and complex continuing care (CCC) hospitals. TC LHIN providers will need to employ the same intensive cross-sector approach that was used to bring down ALC levels in acute care to address ALC in rehab and CCC hospitals.

In 2011/12, the TC LHIN also had a series of initiatives to support patients waiting in hospital greater than 40 days. These patients tend to have multiple health problems and complex needs; many are not receiving appropriate care.

Sixty-five per cent of the 148 long-stay ALC patients identified at the beginning of 11/12 were transitioned to right place of care. While this is a small number of patients, the impact is enormous. Transferring 1 ALC client, who has been in a hospital for 1 year, makes a bed available for another 10-40 over the next year. Now we will turn our attention to long-stay ALC patients in rehab and CCC hospitals who require a different type of care.

→ The Right Care at the Right Time in the Right Place – Aging at Home

In 2010/11, Toronto Central LHIN invested in 22 Aging at Home initiatives to help seniors live healthier and more independently in their homes and communities.

Over the past year, these initiatives directly benefited approximately 15,000 seniors by helping them access a range of support services in their neighbourhoods, avoid unnecessary hospitalizations and safely transition from hospital back home and to their communities.

The following highlights some of the Aging at Home programs in the TC LHIN over the past year:

Community Navigation and Access Program (CNAP) Becomes Automated

The Community Navigation and Access Program (CNAP) offers a coordinated process and hotline for seniors seeking community support services in their neighbourhoods. Now the entire process has been automated through Resource Matching and Referral, making it easier for seniors to get a range of community supports.

The Stepping Stone

A few years ago, LOFT Community Services and CAMH partnered to create The Stepping Stone Project provides high-support housing for at-risk and frail older adults in the community. Six beds at John Gibson House are reserved for CAMH client referrals and six others are for other community hospitals. CAMH staff – including a psychiatrist, a nurse and an occupational therapist – visit weekly to provide specialized care. As much as possible, CAMH staff remain involved with the clients after they move into permanent housing. Last year, Stepping Stone linked 20 clients to primary care.

Home First

As a result of Home First, 2,600 clients like Mike are being cared for in their homes instead of in a hospital or long-term care home.

At 82, Mike lives with diabetes, congestive heart failure and a myriad of complications.

During multiple visits to hospitals, Mike was asked to consider a long-term care home. But Mike loved his house. He cherished the memories, the warmth and the sense of ownership that came with living in his own home. Unfortunately, the house showed serious structural damage, fractured by age and Mike's inability to make repairs by himself.

The CCAC's Home First program made it possible for Mike to live in his own home. The program was started in January 2011.

Specialized care coordination through the CCAC ensured that Mike had smooth transitions to and from his various visits to the hospital. His doctor makes home visits and monitors his blood sugar through a specialized device installed in his home. Mike's Care Coordinator developed a relationship with his local family health team, physicians and clinical staff.

In addition, the Care Coordinator made arrangements for the Ontario Public Guardian and Trustees Office to handle Mike's finances and help make repairs to his home.

Enhanced Adult Day Program (eADP) Expansion

Capitalizing on the success of the enhanced adult (eADP) day program at Woodgreen Community Services, new eADP programs opened at Providence and St. Christopher House supporting seniors with complex needs who could benefit from the companionship and activities provided at Adult Day Programs but need more intensive support.

Mental Health and Addictions

→ Coordinated Access for Mental Health and Community Support Services

Building on the successful coordinated access model for supportive housing in the TC LHIN, mental health and addictions agencies have joined forces to provide a single access point for clients requiring case management and Assertive Community Treatment Teams (ACTT). This will make it easier for clients to access the services they need.

TC and Central LHINs partnered to develop a coordinated access model to help mental health and addictions clients receiving services in both LHINs.

→ Supportive Housing

In 2011/12 Toronto Central LHIN expanded supportive housing for people living with addictions. As of March 2012, 93 per cent of addictions supportive housing units in the Toronto Central LHIN were secured. Early results indicate that, on average, clients are using the ER 68 per cent less than they were before.

→ Toronto Community Addictions Team (TCAT)

TCAT provides clients with housing and addiction treatment options that work for them. Many of these clients have both mental health and addictions issues and are homeless. TCAT clients are the highest users of withdrawal management services and cycle in and out of the ER. Last year, 93 clients were helped by the TCAT program, 40 of whom get into housing. At the end of 2011/12, clients in the TCAT program had 69 per cent fewer ER visits and used withdrawal management services 75 per cent less.

St. James Town Outreach Program (STOP)

The St. James Town Outreach Program provides intensive case management services and programs to isolated older residents who have serious mental health problems. Over the last year, STOP has helped 109 clients to stay housed by assisting with issues like hoarding, bed bugs and supporting them to pay their rent on time. This program prevented over 25 evictions.

Quality and Equity

Quality Measures

A cornerstone of the TC LHIN's quality improvement strategy is the development of one set of quality indicators for the system.

The LHIN convened an expert group of health professionals, all LHIN-funded sectors, primary care, Toronto Public Health, Ontario Medical Association District 11, Institute for Clinical Evaluative Sciences (ICES), Health Quality Ontario, and patient and caregiver representatives to recommend a focused set of quality indicators for all providers to adopt. In Ontario there has been significant work to develop quality indicators in pockets. This is the first time that all providers in a region are responsible for the same quality metrics for patients.

Quality indicators will be included in service accountability agreements starting in 2012/13. Health Quality Ontario and the Ministry have endorsed TC LHIN's approach to regional quality indicator development and it is serving as a blueprint for other LHINs.

Following are the TC LHINs system quality indicators that all sectors will adopt:

1. Inpatient Readmissions within 30 days of discharge for any reason
2. Repeat unscheduled ER use within 30 days for any reason (may focus on CTAS 4 & 5, less urgent and non-urgent respectively)
3. Percentage of hospital patients (ER or inpatient) who knew various important discharge aspects e.g. danger signals to watch after going home
4. Decision Time (Number of days from the date that the referral is sent to the final response
5. Average days waiting from acceptance to admission (Acute/Rehab/CCC/LTCH) and Assessment time (CCAC/CSS) (RM&R and others)
6. Percent of patients with complex high care needs identified that are targeted/receiving appropriate care (e.g. intensive case management (Developmental)

Quality Indicators

Senior Friendly Hospital

TC LHIN led the provincial Senior Friendly Hospital initiative to improve safety, physical and cognitive functioning and resiliency of seniors in hospitals. By the end of the year, 155 hospitals completed self-assessments, the first step towards creating a Senior Friendly Hospital improvement plan. Each hospital in the province will adopt one indicator that will be measured and reported as part of their Quality Improvement Plans (Excellent Care for All requirement) and Accountability Agreement with the LHIN.

Preventing Falls

TC LHIN is implementing a local Falls Prevention program as part of a provincial strategy. TC LHIN's strategy is being led by Baycrest in collaboration with Toronto Public Health and other stakeholders that have a part to play in reducing seniors' risk of falling.

Behavioural Supports Ontario (BSO) Strategy

The TC LHIN launched a local Behavourial Support Action Plan as part of the provincial Strategy. Guided by the goal of "enhancing care of the person behind the illness" the action plan enhances services for seniors with behavioural issues resulting from dementia and mental illness.

"With the LHIN-wide behavioural supports program the hope is that it will provide the same kind of continuity we provide to patients and caregivers at Baycrest, in a broader way across the LHIN."

Dr. Sidney Feldman, *Chief of Family and Community Medicine, Baycrest*

Seniors will have access to a 23-bed Behavioural Support Unit at Baycrest, an outreach program led by WoodGreen, mobile crisis supports and additional services in long-term care homes and their communities.

Caregiver support

The goal of the Caregiver Framework for Seniors Pilot Project is to increase caregiver resiliency. Health professionals are trained in Problem Solving Therapy to help caregivers pinpoint the factors that contribute to stress, and develop an individualized, self-directed care plan. Caregivers are provided with stipends to use however they wish in order to relieve the burden of care-giving.

The pilot began in early October and as of March served 137 caregivers.

A similar pilot is underway through Sick Kids focusing on the caregivers of medically complex children. As of early February, this project served 40 children and their caregivers.

→ Promoting Equity

In 2011/12, the Toronto Central LHIN launched a Health Equity Action Plan with three targeted strategies:

- Share and Expand Phone Interpretation for non-English speaking people;
- Better access for populations without health insurance, starting with an agreement to streamline referrals between CHCs and hospitals;
- Equity indicators and equity data collection at the point of care.

The TC LHIN has made progress on all three of these strategies. While the projects for collecting equity data and developing indicators were delayed somewhat, both initiatives will be fully implemented over the next two years.

Health Access St. James Town

Health equity is an integral part of quality health care. One example of how TC LHIN initiatives are helping to lift the barriers people face when they try to access health care is Health Access St. James Town.

Health Access St. James Town was initiated as a collaborative effort among St. James Town residents, health care organizations, the City of Toronto and the United Way to develop an integrated model for delivering services to this densely-populated neighbourhood.

Based on evidence and broad engagement of residents, health care and City, this project will initially target vulnerable seniors, newcomers, and children, youth and their families. The future of health care in St. James Town could mean bringing more services into people's homes, into their buildings, into safe, familiar locations like schools, libraries, community centres. This scalable model will be applied to other high-density communities in the future.

→ Health System Capacity and Planning

Over the last year, Toronto Central LHIN and health service providers undertook a number of initiatives to improve efficiencies and reduce costs, while maintaining high quality services.

Creating a more integrated health care system

TC LHIN Phone Interpretation Service

In 2011, Toronto Central brought together hospitals from within and outside the LHIN to bulk purchase phone interpretation services. The will allow health service providers to offer more non-English speaking patients access to high quality phone interpretation service, at a lower cost.

Resource Matching and Referral (RM&R)

With Resource Matching and Referral, health care organizations across the continuum of care are using one system to match and refer patients to services that meet their needs, faster. The Resource Matching and Referral System is being expanded to include more TC LHIN health services - inpatient hospital units, outpatient areas and ERs for CCAC in-home referrals as well as 30 community support agencies.

TC LHIN leads the provincial roll out of RM&R. Providers in all areas of the province have taken an important first step by developing standards for referrals within the project's three geographic clusters across Ontario.

Stroke and Orthopedic Care Pathways

TC LHIN providers are not meeting the recommended best practices for stroke and hip fractures.

- On average, stroke patients discharged within five to 7 days have a better prognosis than those who stay in hospital longer. The average length of stay for stroke patients in TC LHIN hospitals is 10.8 days.
- The best practice is for hip fracture patients to leave hospital after an average of 7 days. In TC LHIN the average length of stay is 11.5 days.

TC LHIN hospitals –with the leadership of Dr. Barry McLellan, CEO, Sunnybrook Health Sciences Centre – spearheaded the development of a new model of delivering stroke and orthopedic care (e.g., hip fractures) that will improve quality of care and make better use of resources.

Hospitals and other providers across the continuum GTA-wide worked together to determine the current state for stoke, total joint replacement and hip fractures and recommended a future model that would simplify referrals while locating services in hospitals that specialize in stroke and orthopedic care.

Voluntary Integrations	Goals
University Health Network and Rehabilitation Institute	Will help patients to transition from acute to rehab, lower wait times and enable earlier rehabilitation.
Sunnybrook Health Sciences Centre (TC LHIN) and St. Johns Rehabilitation Hospital (Central LHIN)	A more seamless pathway will be created for patients and reduce wait times for patients moving from acute to rehabilitation.
WoodGreen Community Services and Community Care East York	Making service delivery more efficient by reducing duplication, this merger will expand client programs, strengthen the capacity of the new organization and stimulate innovation among the sector.
Clinical and Service Integrations	**Goals**
Virtual Ward	Clinical teams replicate the care patients receive in the hospital and at home, including 24-hour, 7-day a week access to physicians.
Integrated Client Care Project	This project supports client in innovative ways starting with homebound seniors with high needs. Patients are supported through case conferencing, joint home visits by multiple health service providers and patients are supported by a portable patient record and intensive case management. Last year, 200 clients were supported by this project.
Long-stay ALC	Teams of providers from across sectors transition long-stay ALC patients to the right place of care and prevent people from becoming long-stay ALC patients.
Orthopedic and Stroke Care	Providers from across all sectors determine how best to organize stroke and orthopedic services and use existing resources to improve patient outcomes.
Providence Health Care's New Model of Care	Patients will transition earlier and effectively from inpatient to outpatient and community-based care. This model includes shifting funding from Providence to CCACs as well as clinical integration between Providence's outpatient services and home care.
Scarborough Hospital- Good Shepherd Non-Profit Homes	The hospital transferred a supportive housing program for mental health and addictions clients to Good Shepherd which has given clients increased access to more social and recreational services in the community.
Support Services	**Goals**
The Toronto Central LHIN Laboratory Collaborative	Once fully implemented, this integrated lab will yield annual savings of $15 to 16 million.
Providence and Toronto East General Integrated Pharmacy Services	Toronto East General Hospital is now providing some pharmacy services to Providence at cost with no additional fees. This is a step toward a larger pharmacy integration in the TC LHIN.

Health System Performance and Accountability

In 2011/12 Toronto Central LHIN's performance on some key health system performance indicators has steadily improved, while performance on other indicators declined.

Success Stories

ER Wait Times and ALC

The TC LHIN improved on its targets for ER wait times and met its ALC target of 10% in the third quarter despite increasing demand for Toronto Central LHIN acute care services last year.

While the number ALC patients in acute hospitals waiting for long-term care continued to fall, ALC patients in acute hospitals waiting for Rehab/Complex Continuing Care (CCC) grew. There are challenges both with transferring patients into rehab/ CCC hospitals and in discharging patients from rehab/CCC to long-term care given the high occupancy rates (99%) in TC LHIN LTC homes.

MRI Wait times

More people are being seen within the target wait times for MRIs. Last year, the Toronto Central LHIN performed better that its target for MRI wait times for the first time. This improvement is a result of efficiency measures taken by TC LHIN hospitals and the increased availability of MRI machines in surrounding LHINs which is enabling patients who would normally come to Toronto Central for services to receive tests closer to home.

Areas for Improvement

In 2011/12, Toronto Central LHIN did not meet its targets for a number of indicators.

CT Wait Times

In the past hospital inpatients were the first to get access to CT scans. This created a perverse incentive for physicians to admit ER patients so that they could get quicker access to CT scans. Now hospitals are providing access to inpatient and outpatient CT scans based on need. ER patients are getting faster access whereas those with less urgent needs are waiting longer. In addition, as a result of improved CT technology, some patients are receiving CT scans instead of MRIs. These factors are contributing to somewhat elevated CT scan wait times this past year.

Hospitals had some success improving appropriate use of CT scans. St. Michael's used protocols for abdominal pain patients in ER and reduced unnecessary CT in a few months.

Hip and Knee Surgery Wait Times

Waits for hip and knee replacement surgery have gone up mainly because more patients are coming to the TC LHIN from elsewhere and they choose to wait for preferred surgeons. However, when people waiting for preferred surgeons are not included in the count, most patients are waiting within with the recommended target. Demand

Toronto Central LHIN Performance Indicators

* A negative percentage means the LHIN is below its target

** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability

*** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability

	Performance Indicator	LHIN 2011/12 Starting Point	LHIN 2011/12 Performance Target	Most Recent Quarter 2011/12 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result
Emergency Room/Alternate Level of Care						
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	10.78%	10.00%	10.14%	1.4%	10.36%
2	90th Percentile ER Length of Stay for Admitted Patients	27.72	23.00	27.63	20.1%	25.88
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8.20	8.00	8.15	1.9%	8.10
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	5.12	4.50	5.10	13.3%	4.88
Surgical Wait Times						
5	90th Percentile Wait Times for Cancer Surgery	65	70	67	-4.3%	62
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	48	44	36	-18.2%	46
7	90th Percentile Wait Times for Cataract Surgery	106	100	115	15.0%	117
8	90th Percentile Wait Times for Hip Replacement	124	135	183	35.6%	155
9	90th Percentile Wait Times for Knee Replacement	125	140	190	35.7%	174
Diagnostic Wait Times						
10	90th Percentile Wait Times for Diagnostic MRI Scan	132	115	101	-12.2%	98
11	90th Percentile Wait Times for Diagnostic CT Scan	33	28	40	42.9%	39
Excellent Care for All/Quality						
12	Readmission within 30 Days for Selected CMGs**	19.17%	18.00%	19.71%	9.5%	18.89%
Mental Health and Substance Abuse						
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	25.80%	25.00%	25.47%	1.9%	24.62%
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	37.40%	35.00%	37.60%	7.4%	37.43%
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	33.00	31.40	32.00	1.9%	33.00

for hip and knee surgery in the TC LHIN went up 20% from March 210 to February 2012 while incremental funding to TC LHIN hospitals for hip and knee surgeries went down 15%. This is part of an effort to redistribute funding to GTA to enable people to receive surgery closer to home.

→ Cataract Surgeries

Cataract surgical wait times continue to challenge Toronto Central LHIN. Patient demand for both routine and specialized cataract surgery continues to grow at a higher rate than the capacity within the LHIN. TC LHIN hospitals and the Kensington Eye Institute are working together to transfer routine surgeries to Kensington which will create greater capacity in hospitals for specialized surgeries.

Looking Ahead to 2012/13

While we have made progress in the health care system over the past year, significant challenges remain.

There is a disconnect between what patients say they need and how the health care system is organized. Services are fragmented and people find it difficult to make their way from one part of the system to another.

Toronto is rich in diversity but also marked with inequities. Many people in the city enjoy a high standard of living and a high standard of health care. Others struggle and have great difficulty accessing the services they need.

As a result of the prolonged economic downturn and the province's historic $15 B deficit, over the next few years we cannot count on new funding to resolve health care challenges.

In the year ahead, the TC LHIN and health services providers will step up efforts to transform the system in order to improve health outcomes and sustain publicly funded health care for all.

Our Board of Directors

Name	Position	Appointed	End of Term	Length of Term
Blickstead, Richard	Director	November 3, 2010	November 2, 2013	3 years
Coyles, Stephanie	Director	October 29, 2008 November 25, 2011	October 28, 2011 November 24, 2012	3 years 1 year
Ferrante, Angela	Chair	November 3, 2012	November 2, 2013	3 years
Fraser, John	Director	June 27, 2011	June 26, 2014	3 years
Gallagher-Ross Kathleen	Director	April 18, 2011	April 17, 2014	3 years
Komori, Lloyd	Director	August 21, 2008 August 21, 2011	August 20, 2011 August 20, 2014	3 years 3 years
Magill, Dennis	Director	March 7, 2007 March 7, 2010	March 6, 2010 March 6, 2013	3 years 3 years
Nott, Harley	Director	June 2, 2005 June 2, 2008	June 1, 2008 June 1, 2011	3 years 3 years
Perry, Carol	Director	June 2, 2011	June 1, 2014	3 years
Virmani, Anju	Director	May 14, 2008 May 14, 2011	May 13, 2011 May 13, 2012	3 years 1 year

*Please note: The TC LHIN has nine Board Members at any one time.

Richard Blickstead
Director

Stephanie Coyles
Director

Angela Ferrante
Chair

John Fraser
Director

Kathleen Gallagher-Ross
Director

Lloyd Komori
Director

Dennis Magill
Director

Harley Nott
Director

Carol Perry
Director

Anju Virmani Kumar
Director

Deloitte.

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Toronto Central Local Health Integration Network

We have audited the accompanying financial statements of the Toronto Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Membre de / Member of Deloitte Touche Tohmatsu Limited

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2012, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
June 6, 2012

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**392,175**	1,618,218
Due from Local Health Integration Networks ("LHINs") (Note 3)	**301,836**	190,390
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**13,537,634**	59,651,414
HST receivable	**574,623**	322,081
	14,806,268	61,782,103
Liabilities		
Accounts payable and accrued liabilities	**1,383,215**	2,192,348
Due to HSPs	**13,537,634**	59,651,414
Due to MOHLTC (Note 4b)	**1,297**	30,837
Deferred capital contributions (Note 5)	**1,640,726**	465,091
	16,562,872	62,339,690
Net debt	**1,756,604**	557,587
Non-financial assets		
Prepaid expenses	**115,878**	92,496
Capital assets (Note 6)	**1,640,726**	465,091
	1,756,604	557,587
Accumulated surplus	-	-

Approved by the Board

Director

Director

Toronto Central Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (Unaudited - Note 7)	2012 Actual	2011 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding	5,818,921	5,559,386	5,773,491
Ministry of Health and Long-Term Care ("MOHLTC") funding to LHINC	670,000	670,000	670,000
Health Service Provider ("HSP") transfer payments (Note 8)	4,264,645,757	4,506,874,309	4,364,963,326
E-Health (Note 9)	600,000	600,000	710,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	27,500	27,500	49,600
Emergency Room and Alternate Level of Care ("ER/ALC") (Note 12	100,000	100,000	100,000
Critical Care (Note 13)	75,000	75,000	75,000
Resources Matching Referrals (Note 14)	-	387,000	200,000
French Language Health Services (Note 15)	106,000	106,000	141,400
French Planning Entities (Note 16)	568,713	568,713	192,178
Primary Care Lead (Note 17)	-	21,875	-
Behaviour Support Ontario (Note 18)	-	57,000	-
Amortization of deferred capital contributions (Note 5)	-	482,142	363,948
Amounts recovered/recoverable from the LHINs to LHINC	650,000	354,558	683,000
Amounts recovered/recoverable from the LHINs to LSSO	5,032,924	4,756,393	4,823,435
	4,278,369,815	4,520,714,876	4,378,820,378
Funding repayable to the MOHLTC (Note 4a)	-	(1,297)	(30,837)
	4,278,369,815	4,520,713,579	4,378,789,541
Expenses			
Transfer payments to HSPs (Note 8)	4,264,645,757	4,506,874,309	4,364,963,326
General and administrative (Note 19)	5,818,921	5,700,352	5,785,344
LHIN Shared Services Office expense (Note 20)	5,032,924	5,096,272	5,174,815
LHIN Collaborative (Note 21)	1,320,000	1,024,558	1,353,000
E-Health (Note 9)	600,000	600,000	710,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	27,500	27,500	49,600
Emergency Room and Alternate Level of Care (ER/ALC) (Note 12)	100,000	100,000	100,000
Critical Care (Note 13)	75,000	75,000	75,000
Resources Matching Referrals (Note 14)	-	387,000	200,000
French Language Health Services (Note 15)	106,000	106,000	111,278
French Planning Entities (Note 16)	568,713	568,713	192,178
Primary Care Lead (Note 17)	-	21,875	-
Behaviour Support Ontario (Note 18)	-	57,000	-
	4,278,369,815	4,520,713,579	4,378,789,541
Annual surplus and closing accumulated surplus	-	-	-

Toronto Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012	2011
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(1,657,777)**	(45,431)
Amortization of capital assets	**482,142**	363,948
Change in other non-financial assets	**(23,382)**	(40,995)
(Increase) decrease in net debt	**(1,199,017)**	277,522
Opening net debt	**(557,587)**	(835,109)
Closing net debt	**(1,756,604)**	(557,587)

Toronto Central Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of capital assets	**482,142**	363,948
Amortization of deferred capital contributions (Note 5)	**(482,142)**	(363,948)
	-	-
Changes in non-cash operating items		
Increase in due from LHINs	**(111,446)**	(157,218)
Increase in HST receivable	**(252,542)**	(322,080)
Decrease (increase) in due from MOHLTC regarding HSP transfer payments	**46,113,780**	(57,317,715)
(Decrease) increase in accounts payable and accrued liabilities	**(809,133)**	102,764
(Decrease) increase in due to HSPs	**(46,113,780)**	57,317,715
Decrease in due to MOHLTC	**(29,540)**	(15,233)
Decrease in deferred revenue	-	(66,700)
Increase in prepaid expenses	**(23,382)**	(40,995)
	(1,226,043)	(499,462)
Capital transaction		
Acquisition of capital assets	**(1,657,777)**	(45,431)
Financing transaction		
Increase in deferred capital contributions (Note 5)	**1,657,777**	45,431
Net change in cash	**(1,226,043)**	(499,462)
Cash, beginning of year	**1,618,218**	2,117,680
Cash, end of year	**392,175**	1,618,218

Toronto Central Local Health Integration Network

Notes to the financial statements
March 31, 2012

1. Description of business

The Toronto Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Toronto Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the City of Toronto. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"). These financial statements reflect the terms of the MLPA related to this funding.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2012.

The LHIN financial statements do not include any MOHLTC managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect the terms of the agreement.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and losses in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are initially recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Segmented financial reporting

The financial statements of the LHIN include the accounts of the LHIN Shared Services Office (the "LSSO") and LHIN Collaborative (the "LHINC") which are its divisions. Separate schedules of LSSO and LHINC financial position and financial activities are presented in the attached schedules to the financial statements.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at year end are recorded as a receivable (payable) to (from) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LHINC is responsible for providing advice to all LHINs in the areas of planning integration and community engagement, allocation methodologies, accountability performance and system alignment and co-ordination. Any portion of the LHINC operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to (from) the LHINC. This is all done pursuant to the LHINC Agreement the LHINC has with all the LHINs.

4. Funding repayable to the MOHLTC

In accordance with the MLPA and the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC and eHealth Ontario respectively.

a. The amount repayable to the MOHLTC related to the current activities is made up of the following components:

			2012	2011
	Funding received	Eligible expenses	Excess funding	Excess funding
	$	$	$	$
Transfer payments to HSPs	4,506,874,309	4,506,874,309	-	-
LHIN operations	5,701,649	5,700,352	1,297	715
LHINC	670,000	670,000	-	-
E-Health	600,000	600,000	-	-
ED Leads	75,000	75,000	-	-
Aboriginal Health Transition Planning	27,500	27,500	-	-
ER/ALC	100,000	100,000	-	-
Critical Care Leads	75,000	75,000	-	-
ALC Resources Matching	387,000	387,000	-	-
Primary Care lead	21,875	21,875	-	-
Behaviour Support Ontario	57,000	57,000	-	-
FLHS	106,000	106,000	-	30,122
French Planning Entities	568,713	568,713	-	-
	4,515,264,046	4,515,262,749	1,297	30,837

4. Funding repayable to the MOHLTC (continued)

b. The amount due to the MOHLTC at March 31 is made up as follows:

	2012	2011
	$	$
Due to MOHLTC, beginning of year	(30,837)	(46,070)
MOHLTC payment	30,837	46,070
Funding repayable to the MOHLTC related to current year activities (Note 4a)	(1,297)	(30,837)
Due to MOHLTC, end of year	(1,297)	(30,837)

5. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	465,091	783,608
Capital contributions received during the year	1,657,777	45,431
Amortization for the year	(482,142)	(363,948)
Balance, end of year	1,640,726	465,091

6. Capital assets

	Cost	Accumulated amortization	2012 Net book value	2011 Net book value
	$	$	$	$
Office furniture and fixtures	338,896	251,686	87,210	-
Computer equipment	3,631,532	2,081,539	1,549,993	460,393
Leasehold improvements	1,261,883	1,258,360	3,523	4,698
	5,232,311	3,591,585	1,640,726	465,091

7. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2011. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $ 4,506,874,309 is made up of the following:

	$
Initial HSP Funding budget	4,264,645,757
Adjustment due to announcements made during the year	242,228,552
Total HSP Funding budget	4,506,874,309

7 Budget figures (continued)

The total operating budget, excluding HSP Funding, of $7,837,009 is made up of the following:

	$
Initial operating budget	7,371,134
Additional funding received during the year for	
Resources Matching Referrals (Note 14)	387,000
Primary Care Lead (Note 17)	21,875
Behaviour Support Ontario (Note 18)	57,000
Revised operating budget	7,837,009

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $ 4,506,874,309 (2011 - $4,364,963,326) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2012 as follows:

	2012	2011
	$	$
Operation of hospitals	3,469,916,380	3,402,000,919
Grants to compensate for municipal taxation - public hospitals	747,300	743,250
Long-term care homes	251,359,885	237,332,764
Community care access centre	210,048,791	205,621,957
Community support services	74,769,503	44,287,376
Assisted living services in supportive housing	44,829,549	43,964,652
Community health centres	81,843,270	77,213,192
Community mental health addictions program	104,420,160	93,891,490
Addictions program	26,545,666	24,420,104
Specialty psychiatric hospital	242,349,255	235,443,072
Grants to compensate for municipal taxation - psychiatric hospitals	44,550	44,550
	4,506,874,309	4,364,963,326

9. E-Health

The LHIN received funding of $ 600,000 (2011 - $710,000) related to the E-Health project. E-Health expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	445,889	512,047
Translation services	-	1,463
Consulting services	-	92,750
Other	154,111	103,740
	600,000	710,000

10. Emergency Department ("ED") leads

The LHIN received funding of $ 75,000 (2011 - $75,000) related to the ED Leads project. ED Leads expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	3,000	1,400
Consulting services	72,000	69,000
Other	-	4,600
	75,000	75,000

11. Aboriginal Health Transition Planning

The LHIN received funding of $ 27,500 (2011 - $49,600) related to the Aboriginal Health Transition Planning Project. Aboriginal Health Transition Planning expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	18,459	44,146
Other	9,041	5,454
	27,500	49,600

12. Emergency Room and Alternate Level of Care (ER/ALC)

During the year, the LHIN was provided funding of $ 100,000 (2011 - $100,000) from the MOHLTC for the ER/ALC program. The LHIN incurred $ 100,000 (2011 - $100,000) ER/ALC expenses related to salaries and benefits.

13. Critical Care (CC) leads

During the year, the LHIN received funding of $ 75,000 (2011 - $75,000) related to the Critical Care Leads project. CC Leads expenses incurred during the year are as follows,

	2012	2011
	$	$
Salaries and benefits	1,269	1,869
Consulting services	72,000	72,750
Other	1,731	381
	75,000	75,000

14. Resources Matching Referrals Leads (ALC RMR)

During the year, the LHIN was provided funding of $ 387,000 (2011 - $200,000) from the MOHLTC for the RMR project. RMR expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries and benefits	**330,717**	199,985
Other	**56,283**	15
	387,000	200,000

15. French Language Health Services (FLHS)

During the year, the LHIN was provided funding of $ 106,000 (2011 - $141,400) from the MOHLTC for the French Language Health Services program. FLHS expenses incurred during the year as follows:

	2012	2011
	$	$
Salaries and benefits	**85,105**	46,369
Translation services	**17,461**	29,554
Consulting services	**-**	5,750
Other	**3,434**	29,605
	106,000	111,278

16. French Planning Entities

During the year, the LHIN was provided funding of $ 568,713 (2011 - $192,178) from the MOHLTC for the French Planning Entities and the funds were flowed directly to "Entité de planification pour les services de santé en français de Toronto Centre".

17. Primary Care Lead

During the year, the LHIN received new funding of $ 21,875 from the MOHLTC for the Primary Care Lead program. The expenses incurred during the year as follows:

	$
Salaries and benefits	**6,670**
Computer charges	**4,788**
Consulting services	**6,250**
Other	**4,167**
	21,875

18. Behaviour Support Ontario

During the year, the LHIN received new funding of $ 57,000 from the MOHLTC for the Behaviour Support Ontario (BSO) program. BSO expenses of $57,000 incurred during the year consisted of salaries and benefits.

19. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies general and administrative expenses by object:

	2012	2011
	$	$
Salaries and benefits	3,969,929	4,519,036
Occupancy	236,159	258,548
Amortization	142,264	12,568
Shared services	539,499	305,695
LHINC	26,971	50,000
Public affairs and communications	13,470	9,256
Consulting services	56,726	220,914
Translation services	15,257	9,393
Professional services	12,819	23,645
Supplies	78,409	66,626
Computer expenses	330,366	16,640
Governance	48,356	55,866
Mail, courier and telecommunications	42,911	48,697
Other	187,216	188,460
	5,700,352	5,785,344

The following lists the Board Chair and Directors per diem costs as well as their travel and expenses which are included in governance expense in the general and administrative expenses above.

	2012		2011
	Budget	Actual	Actual
	$	$	$
Board Chair per diem cost	54,600	22,050	22,475
Directors per diem cost	103,500	25,825	32,100
Board travel and expenses	6,900	481	1,291
	165,000	48,356	55,866

20. Common LHIN services expenses

The Statement of Financial Activities presents the common LHIN services expenses by function, the following classifies the same expenses by object.

During the year, LSSO received additional funding from the LHINs for IT-related projects, which is allocated to computer expenses and capital additions for the year.

	2012	2011
	$	$
Salaries	1,727,135	1,556,568
Benefits	210,956	222,066
Supplies	23,690	29,620
Telecommunications	17,717	17,312
Recruitment and staff development	16,853	10,294
Computer expense	944,843	508,995
Consulting fees	173,494	606
Professional services	21,050	15,099
Meeting expenses	7,479	4,806
Amortization	339,879	351,380
Occupancy	160,499	180,770
Other	38,582	59,673
Shared services	2,066,587	2,577,121
Total common LHIN services expenses	5,748,764	5,534,310
Less: inter-entity transactions eliminated on combination	(652,492)	(359,495)
	5,096,272	5,174,815

21. Collaborative LHIN services expenses

The Statement of Financial Activities presents the collaborative LHIN services expenses by function; the following classifies the same expenses by object:

LHINC receives $ 670,000 funding from MOHLTC and the balance of the revenue from all the LHINs. Costs allocation is based on the percentage proportionate on the funding received.

	LHINs	MOHLTC	2012 Total	2011 Total
	$	$	$	$
Salaries	229,933	407,999	637,932	989,745
Benefits	53,108	94,237	147,345	242,422
Supplies	3,269	5,800	9,069	2,274
Telecommunications	7,618	13,518	21,136	38,677
Recruitment and staff development	1,269	2,252	3,521	3,825
Computer expense	3,625	6,433	10,058	6,734
Consulting fees	10,946	19,424	30,370	16,547
Meeting expenses	154	271	425	25,432
Occupancy	33,915	60,179	94,094	70,640
Other	4,916	8,722	13,638	6,704
Shared services	28,835	51,165	80,000	-
	377,588	670,000	1,047,588	1,403,000
Less: inter-entity transactions eliminated on combination	(23,030)	-	(23,030)	(50,000)
	354,558	670,000	1,024,558	1,353,000

22. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 64 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $ 438,200 (2011 - $467,710) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2011. At that time, the plan was fully funded.

23. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the Financial Administration Act.

24. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due over the next five fiscal years are as follows:

	$
2013	621,799
2014	639,851
2015	658,390
2016	334,090
2017	-

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2013 and 2014. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

25. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule 1
year ended March 31, 2012

	2012	2011	2012	2011	2012	2011	2012	2011
	Toronto Central		Shared Services Office		Collaborative		Total	Total
	$	$	$	$	$	$	$	$
Financial assets								
Cash	419,490	936,490	(178,472)	457,810	151,157	223,918	392,175	1,618,218
Due from LSSO/LHINC/TC LHIN*	61,398	111,506	60,237	-	-	-	121,635	111,506
Due from Local Health Integration Network ("LHIN")	-	-	301,836	157,390	-	33,000	301,836	190,390
Due from Ministry of Health and Long-Term Care ("MOHLTC")	-	-	-	-	-	-	-	-
Due from MOHLTC regarding HSP transfer payments	13,537,634	59,651,414	-	-	-	-	13,537,634	59,651,414
HST receivable	208,723	90,033	364,894	226,367	1,006	5,681	574,623	322,081
	14,227,245	60,789,443	548,495	841,567	152,163	262,599	14,927,903	61,893,609
Liabilities								
Accounts payable and accrued liabilities	663,865	1,160,887	624,214	695,426	95,136	336,035	1,383,215	2,192,348
Due to LSSO/LHIN/TC LHIN*	55,967	-	-	184,498	65,668	(72,992)	121,635	111,506
Due to HSPs	13,537,634	59,651,414	-	-	-	-	13,537,634	59,651,414
Deferred capital contributions	284,525	45,430	1,356,201	419,661	-	-	1,640,726	465,091
Due to Ministry of Health and Long-Term Care ("MOHLTC")	1,297	30,837	-	-	-	-	1,297	30,837
	14,543,288	60,888,568	1,980,415	1,299,585	160,804	263,043	16,684,507	62,451,196
Net debt	(316,043)	(99,125)	(1,431,920)	(458,018)	(8,641)	(444)	(1,756,604)	(557,587)
Non-financial assets								
Prepaid expenses	31,518	53,695	75,719	38,357	8,641	444	115,878	92,496
Capital assets	284,525	45,430	1,356,201	419,661	-	-	1,640,726	465,091
Accumulated surplus	-	-	-	-	-	-	-	-

* Amounts due from/to the LHIN Shared Services Office, due from/to the LHINC and due from/to TC LHIN are eliminated upon combination.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule I (continued)
year ended March 31, 2012

	2012 Toronto Central Operations		2011	2012 Shared Services Office		2011	2012 Collaborative		2011	2012	2011
	Budget	Actual	Actual	Budget	Actual	Actual	Budget	Actual	Actual	Total	Total
	$	$	$	$	$	$	$	$	$	$	$
Revenue											
Amounts recovered/recoverable from the LHINs	-	-	-	5,032,924	5,408,885	5,182,930	650,000	377,588	733,000	5,786,473	5,915,930
MOHLTC funding	5,818,921	5,559,386	5,773,491	-	-	-	670,000	670,000	670,000	6,229,386	6,443,491
HSP transfer payments (Note 8)	4,264,645,757	4,506,874,309	4,364,963,326	-	-	-	-	-	-	4,506,874,309	4,364,963,326
E-Health funding (Note 9)	600,000	600,000	710,000	-	-	-	-	-	-	600,000	710,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	27,500	27,500	49,600	-	-	-	-	-	-	27,500	49,600
Emergency Room and Alternate Level of Care (ER/ALC) (Note 12)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care (Note 13)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 14)	-	387,000	200,000	-	-	-	-	-	-	387,000	200,000
French Language Health Services (Note 15)	106,000	106,000	141,400	-	-	-	-	-	-	106,000	141,400
French Planning Entities (Note 16)	568,713	568,713	192,178	-	-	-	-	-	-	568,713	192,178
Primary Care Lead (Note 17)	-	21,875	-	-	-	-	-	-	-	21,875	-
Behaviour Support Ontario (Note 18)	-	57,000	-	-	-	-	-	-	-	57,000	-
Amortization of deferred capital contributions (Note 5)	-	142,263	12,568	-	339,879	351,380	-	-	-	482,142	363,948
	4,272,016,891	4,514,594,046	4,372,292,563	5,032,924	5,748,764	5,534,310	1,320,000	1,047,588	1,403,000	4,521,390,398	4,379,229,873
Funding surplus repayable to the MOHLTC (Note 4(a))	-	(1,297)	(30,837)	-	-	-	-	-	-	(1,297)	(30,837)
	4,272,016,891	4,514,592,749	4,372,261,726	5,032,924	5,748,764	5,534,310	1,320,000	1,047,588	1,403,000	4,521,389,101	4,379,199,036
Expenses											
General and administrative (Note 19)	5,818,921	5,700,352	5,785,344	-	-	-	-	-	-	5,700,352	5,785,344
Common LHIN Services* (Note 20)	-	-	-	5,032,924	5,748,764	5,534,310	-	-	-	5,748,764	5,534,310
LHIN Collaborative** (Note 21)	-	-	-	-	-	-	1,320,000	1,047,588	1,403,000	1,047,588	1,403,000
Transfer payments to HSPs (Note 8)	4,264,645,757	4,506,874,309	4,364,963,326	-	-	-	-	-	-	4,506,874,309	4,364,963,326
E-Health (Note 9)	600,000	600,000	710,000	-	-	-	-	-	-	600,000	710,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Aboriginal Health Transition Planning (Note 11)	27,500	27,500	49,600	-	-	-	-	-	-	27,500	49,600
Emergency Room and Alternate Level of Care (ER/ALC) (Note 12)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care (Note 13)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Resources Matching Referrals (Note 14)	-	387,000	200,000	-	-	-	-	-	-	387,000	200,000
French Language Health Services (Note 15)	106,000	106,000	111,278	-	-	-	-	-	-	106,000	111,278
French Planning Entities (Note 16)	568,713	568,713	192,178	-	-	-	-	-	-	568,713	192,178
Primary Care Lead (Note 17)	-	21,875	-	-	-	-	-	-	-	21,875	-
Behaviour Support Ontario (Note 18)	-	57,000	-	-	-	-	-	-	-	57,000	-
	4,272,016,891	4,514,592,749	4,372,261,726	5,032,924	5,748,764	5,534,310	1,320,000	1,047,588	1,403,000	4,521,389,101	4,379,199,036
Annual surplus and closing accumulated surplus	-	-	-	-	-	-	-	-	-	-	-

* These amounts will be adjusted by $652,492 for Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs (Note 20)
** These amounts will be adjusted by $23,030 for Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs (Note 21)

Local Health Integration Network
Local Shared Services Office

Schedule of financial position and financial activities - Schedule II
year ended March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	(178,472)	457,810
Due from LHINs	301,836	157,390
HST receivable	364,894	226,367
	488,258	841,567
Liabilities		
Accounts payable and accrued liabilities	624,214	695,426
Due to TC LHIN*	(55,967)	98,762
Due to LHINC*	(4,270)	85,736
Deferred capital contribution	1,356,201	419,661
	1,920,178	1,299,585
Net debt	(1,431,920)	(458,018)
Non-financial assets		
Prepaid expenses	75,719	38,357
Capital assets	1,356,201	419,661
Accumulated surplus	-	-

	Budget (Unaudited)	2012 Actual	2011 Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	5,032,924	5,408,885	5,182,930
Amortization of deferred capital contributions	-	339,879	351,380
	5,032,924	5,748,764	5,534,310
Expenses			
Common LHIN Services	5,032,924	5,748,764	5,534,310
Annual surplus	-	-	-

* Amounts due to TC LHIN and LHINC are eliminated upon combination.

Local Health Integration Network
LHIN Collaborative (LHINC)

Schedule of financial position and financial activities - Schedule III
year ended March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	151,157	223,918
Due from Local Health Integration Network ("LHIN")	-	33,000
HST receivable	1,006	5,681
Due from LSSO*	-	85,736
	152,163	348,335
Liabilities		
Accounts payable and accrued liabilities	95,136	336,035
Due to TC LHIN*	65,668	12,744
	160,804	348,779
Net debt	(8,641)	(444)
Non-financial assets		
Prepaid expenses	8,641	444
Accumulated surplus	-	-

		2012	2011
	Budget (Unaudited)	Actual	Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	650,000	377,588	733,000
MOHLTC funding	670,000	670,000	670,000
	1,320,000	1,047,588	1,403,000
Expenses			
Collaborative LHIN expenses	1,320,000	1,047,588	1,403,000
Annual surplus	-	-	-

* Amounts due from the LHIN Shared Services office and due to TC LHIN are eliminated upon combination.